The goal of the School Age Program is to offer an inclusive program with a variety of options for parents with Elementary and Middle school students to participate in a structured environment that nurtures all aspects of the development of children.

A parent may obtain a fall or summer registration packet online from the Forms Center under the Healthy Families category at http://hampton.gov/FormCenter , from any school site location, or the School Age Program Office located at 100 Old Hampton Lane, Hampton, Virginia 23669.

Parent School Age Program Registration Checklist

☐ Prior to filling out the registration packet, the staff must be informed if your child has an IEP (Individualized Education Program) or 504 Plan from the school.

- Your disclosures of conditions that require special attention or accommodations are confidential and do not necessarily exclude your child from participation in the program.
- If your child does have an IEP or 504 Plan from the school for anything other than speech or hearing, you will need to obtain an assessment by Hampton Parks and Recreation Therapeutics to determine whether we have the facility and/or staff to accommodate your child's needs.

☐ The registration packet must be completely filled out. Do not leave any lines blank. If a particular question is not applicable, please list N/A in the space provided.

Note: At least one ***local*** emergency contact ***must*** be listed on the registration form.

Note: Some forms may include a carbon copy. Please separate the carbon forms from the rest of the packet while writing as to not compromise the legibility of your information.

☐ A registration fee in the amount of 20.00 plus a minimum of one week of program service or a minimum of one 5 day pass is due upon turning in your registration packet. Payments must be in the form of check or money order made payable to the City of Hampton and are due the Tuesday before the week of service you are selecting. If you would like to pay by credit card, you must come to the School Age Programs Office, located at 100 Old Hampton Lane, Hampton, VA 23669.

Note: Checks ***cannot*** be post-dated. For money orders, you will need to write your address in the address section and include the same service information listed below as checks.

Note: In the "for" or "memo" section write your child's name, site location, and the service week dates or the 5-day pass start date. Only full payments will be accepted, no partial payments will be taken.

☐ At the time of your registration you will receive a receipt of payment, a payment schedule (if you are signing up for the weekly program) and a parent handbook.

☐ You may also download or print a payment schedule, consent for medication, parent handbook and other School Age Program resources from the Forms Center at http://hampton.gov/FormCenter

Summer Camp **School Age Program Registration and Record Form** Summer Camp

FILL FORM OUT COMPLETELY. ONE REGISTRATION IS NEEDED FOR EACH CHILD. (PLEASE PRINT)

CHILD's NAME: **PROGRAM LOCATION:**_____

LAST FIRST MI

_____ Gender: □M □F DOB: _____ Grade _____ Address:

_____

City: _____ State: ____ Zip: _____ Email Address _____

PARENT, GUARDIAN OR AGENCY HAVING CUSTODY OF CHILD:

NAME	SSN# or DL#	WORK PHONE	HOME PHONE	CELL PHONE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMERGENCY CONTACT/AUTHORIZED PERSON(S) TO PICK-UP CHILD

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

MEDICAL INFORMATION AND DEVELOPMENT ASSESSMENT

In order to meet the needs of your child and to ensure proper placement, please complete the questions below.

Physician's Name: _____ Phone Number _____

1. Does your child take any medication that alters his/her behavior? □ Yes □ No
2. Does your child have the ability to independently toilet him/herself? □ Yes □ No
3. Does your child have any physical limitations? □ Yes □ No
4. Does your child have a 504 plan? □ Yes □ No
5. Is your child able to communicate his/her needs? If No, please explain below. □ Yes □ No
6. Does your child have tantrums? If Yes, provide an appropriate response below. □ Yes □ No
7. Does your child function appropriately for his/her age? If No, please explain below. □ Yes □ No
8. Does your child receive Report Cards (RC) or an IEP? □ RC □ IEP

Please provide explanation and list any health problems or allergies, current medications, limits or restrictions due to health reasons:_____

_____

PARENTAL/GUARDIAN CONSENT FOR TREATMENT

This is to certify that I/We have Hospitalization Insurance with _____ Policy Number _____

Do we have permission to seek medical treatment necessary for your child in case we are unable to contact you? ☐ Yes ☐ No

Please list any health problems or allergies, current medication, limits or restrictions._____

_____

By signing this form,

I/We the undersigned, do hereby authorize that the certified medical centers/hospitals are given the authority to render necessary medical services to my/our child which results, directly or indirectly, from his/her participation in trips, programs, events, activities by the City of Hampton and I/We, the undersigned; also hereby agree to be responsible for such charges made by medical center/hospital, doctor, ambulance, etc., in providing such medical services as are referred to above.

_____ _____

Parent/Guardian Signature Date

ASSUMPTION OF RESPONSIBILITY/RISK

I am aware of the general nature of the program sponsored by the City of Hampton's School Age Program and I hereby assume responsibility for /my child to participate as well as the risks of participation in such a program. I agree to indemnify and hold harmless the City of Hampton, its agents/employees from any loss, damage, claim, demand, liability, or expense incurred as a result of any damage to property or person, caused by my child while participating in the program named above. I declare to the best of my knowledge and belief that my child is in sufficiently good health and physical condition to participate in the program. I agree that my child will, to the best of our knowledge, abide by any physical limitations which limit his/her activities or ability to participate in this program/activity.

Photography Release ☐ I Do ☐ Do not consent & authorize Youth, Education & Family Services to reproduce/publish my children's pictures for the purpose of advertising SAP or any other city program

_____ _____

Parent/Guardian Signature Date

PAYMENT SCHEDULE & PARENT HANDBOOK:

I have received a copy of the program payment schedule & parent handbook.

SIGN_____DATE_____

FOR OFFICE USE ONLY: Today's Date: _____ Program Start Date: _____

Paid For: _____ Registration _____ Weekly _____ Monthly _____ AM _____ PM _____ 5 Day Pass RECEIPT #: _____

Received by: _____ Amt Received: _____CK or MO #_____CC _____

Program Title **Site Location**

Medical, IEP & Special Needs Disclosures

It is the intent of the Youth, Education and Family Services School Age Programs to plan an environment that will facilitate the success of each and every child in our program. It is the responsibility of the parent/guardian to provide accurate assessment information to ensure that the staff is aware and equipped to manage situations that require special attention.

In the best interest of your child and to increase the ability of our staff to meet the needs of your child please complete and answer **ALL** application questions in the **Medical Information and Development Assessment** section of the registration form.

Your disclosures of conditions that require special medical attention, IEP's or accommodations are confidential. Failure to disclose such information places our staff members at a disadvantage and limits our ability to best serve the needs of your child.

If your child is admitted to our program and medical information, IEP's or special needs have not been disclosed your child may be immediately excluded from the program.

Please also be aware that because medical conditions and your child's needs may change over time, periodic re-assessments may be conducted to ensure proper accommodations and adjustments are made that may include, but are not limited to transfer to a more appropriate setting. It is your responsibility to inform staff members immediately of any changes in your child's medical condition or special needs.

Please initial each statement and sign below:

____ I have read the above statements in regard to disclosure of medical, IEP and special needs information and agree to answer all registration application questions with full disclosure.

____ I further understand that as my child's medical condition or needs change my child may be periodically reassessed to determine appropriateness for participation in your before or after school program. I will immediately inform staff of any changes in my child's medical condition or special needs.

_____ _____

Child's Name School

_____ _____

Parent/Guardian Signature Date

INCLUSION, ACCOMMODATION & SPECIAL NEEDS
REQUEST & INFORMATION FORMS

City of Hampton, School Age Programs (SAP) welcomes individuals with disabilities to participate in all recreation programs and activities. Reasonable accommodations are provided to enable individual's successful participation in a program. A minimum of two weeks notice is required to insure appropriate accommodations. Eligibility requirements (age, level of participation) must be met in order to participate. Please complete all questions. Write N/A if it does not apply.
This information should be submitted with your registration form.

PARTICIPANT INFORMATION/ HEALTH RELEASE
Participant Name_____
Age_____ Date of Birth_____Sex___School Attending_____
Parent/Guardian's Full Name
Street Address_____State___ Zip Code_____
E-mail _____
Mother/Guardian Home phone_____Work phone_____Cell phone_____
Father/Guardian Home phone_____ Work phone_____Cell phone _____
Physician Name_____Phone Number_____
Health Insurance Company_____ Policy # _____
Emergency Contact Information (Other than guardian or adult participant listed above)
Name_____ Home phone_____Work phone_____
Special Needs
Please check if any accommodations are needed in the following areas:
☐ Deaf or hard of hearing ☐ Low vision/legally blind
☐ Uses mobility aide (i.e. wheelchair, brace, etc.)
☐ Developmental disability (i.e. autism, mental retardation, etc.)
☐ Attention deficit hyperactivity disorder (ADHD)
☐ Behavioral/emotional disorder- ☐ yes ☐ no Behavior treatment Plan?_____
☐ Other disability accommodation requested *Please elaborate*:_____
_____
☐ Other health concerns. *Please elaborate:*_____
_____
Participant requires special health care? ☐ yes ☐ no
Please elaborate: (i.e. inhaler, nebulizer, etc.) _____
Are there limits on participant's physical activities? ☐ yes ☐ no
Please elaborate: _____
Participant has allergies? ☐ yes ☐ no
*Please specify:*_____
Participant has seizures? ☐ yes ☐ no Medication for seizures? ☐ yes ☐ no If yes, name the medicine and usual treatment:_____Date of last seizure: _____ Type_____

Child Release Authorization
City of Hampton, SAP is authorized to release my child to the following individuals who may pick up my child from the program. I understand that each authorized person must be at least eighteen (18) years old, and that my child will NOT be permitted to leave the program with anyone not listed below. All authorized individuals will be required to show identification.

1. _____
   Name Telephone
2. _____
   Name Telephone

Departure Procedure: What do you wish the departure procedure to be for your child?
☐ Wait for authorized person ☐ Other (detail specifics) _____

_____ _____
Parent/Guardian Signature Date

SCHOOL AGE PROGRAM

HEATLH SERVICE SYNOPTIC HEALTH HISTORY

Dear Parent:
We would like your child to gain the most from his/her camp experience. In order for us to assist in accomplishing this, it is necessary to have a brief current health history. Please complete this form at registration and return it to the School Age Program Staff.

Site: _____

Child's Name: _____

Gender: ☐ F ☐ M Age: _____ Birth Date: _____

Address: _____

Guardian/Parent: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Does you child have a health problem?

___ Allergies	___ Emotional Problem	___ Learning Problem	___ Sickle Cell Anemia
___ Anemia	___ Hearing	___ Mental Retardation	___ Vision
___ Asthma	___ Heart Disease	___ Orthopedic Problem	___ Other (Specify)
___ Diabetes	___ Injury	___ Seizures/Convulsions	

Comments: _____

_____

_____

Special Needs at Program Site: _____

Does your child take medication? ☐ Yes ☐ No

If Yes, please list all medication. _____

_____

_____

_____

Parent/Guardian's Signature _____ Date: _____

SCHOOL AGE PROGRAM

MEDICATION ADMINISTRATION POLICIES MEMO

Date:_____

TO: Parent/Guardian of _____

FROM: The City of Hampton School Age Programs

All prescription medication or special medication purchased over the counter must have an "State DHS Medical Consent Best Practice Form" completed and signed by Physician and parent/guardian.

All medications must be in original package or container with a pharmacy label to include child's name, name of medication, dosage, time of medication must be taken and the doctor's name. All equipment necessary to accurately administer medication must accompany medication (i.e. calibrated measuring spoon or cup).

Medication requiring refrigeration will NOT be accepted based on Virginia State laws. Violators are subject to fines.

Program leader will make every attempt to administer medication daily within the appropriate time within human limits. Please contact program Leader if your child who is a medication recipient will be absent or picked up early from the site.

If you have further questions or concerns, please contact the program Leader at your child's site. Thank you for your understanding and for working with us in the care of your child.

Sincerely,

School Age Programs
City of Hampton
757-727-1300 Option 4

MAT Handout 2.4

Written Medication Consent Form 1of 2

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- Parents MUST complete #1 through #23 (omit #18) for medication to be administered 10 days or less OR for non-prescription topical medication including sunscreen, diaper ointment or insect repellent.
- The child's health care provider MUST complete #1 through #18 for Long-Term medications or when dosage directions state "consult a physician." The parent completes #19 through #23.

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____

8A. Possible side effects: □ Parent must supply package insert (or pharmacy printout) for complete list of possible side effects

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

□ Contact parent □ Contact prescriber at phone number provided below

□ Other (describe): _____

10A. Special instructions: □ Parent must supply package insert (or pharmacy printout) for complete list of special instructions

AND/OR

10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____

11. Reason the child is taking the medication (unless confidential by law):

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

□ No □ Yes If you checked yes, complete #33-#34 on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

□ No □ Yes If you checked yes, complete #35-#36 on the back of this form.

14. Date consent form completed:	15. Date to be discontinued or length of time in days to be given (this date cannot exceed 6 months from the date authorized or this order will not be valid):
16. Prescriber's name (please print):	17. Prescriber's telephone number:

18. Licensed authorized prescriber's signature:

Required for Long-Term medication or when dosage directions state "consult a physician".

Written Medication Consent Form 2of2

PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? (For example, did the prescriber write 12pm?) □Yes □ N/A □ No Write the specific time(s) the child day program is to administer the medication (i.e.: 12pm):_____
20. I, parent/legal guardian, authorize the child day program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to _____ . (child's name)

21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature: _____	

CHILD DAY PROGRAM TO COMPLETE THIS SECTION (#24 - #30)

24. Provider/Facility name:	25. Facility telephone number:	26. County
27. I have verified that #1-#23 and if applicable, #33-#36 are complete. My signature indicates that all information needed to give this medication has been given to the child day program.		
28. Authorized child care provider's name (please print):	29. Date received from parent:	
30. Authorized child care provider's signature:		

ONLY COMPLETE THIS SECTION (#31-#32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

31. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date). Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
32. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #36)

33. Describe any additional training, procedures or competencies the child day program staff will need to care for this child. _____
34. Licensed Authorized Prescriber's Signature:
35. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE:_____ By completing this section the child day program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.
36. Licensed Authorized Prescriber's Signature: